STATE OF CONNECTICUT
OFFICE OF THE CHILD ADVOCATE
18-20 TRINITY STREET, HARTFORD, CONNECTICUT 06105

Sarah Healy Eagan
Child Advocate

TESTIMONY OF THE OFFICE OF THE CHILD ADVOCATE
HUMAN SERVICES COMMITTEE, TUESDAY, FEBRUARY 21, 2023

Senator Lesser, Representative Gilchrest, Senator Seminara, Representative Case, and all distinguished members of the Human Services Committee, this testimony is being submitted on behalf of the Office of the Child Advocate ("OCA"). The obligations of the OCA are to review, investigate, and make recommendations regarding how our publicly funded state and local systems meet the needs of vulnerable children.

S.B. No. 991 (RAISED) AN ACT CONCERNING MEDICAID REIMBURSEMENT FOR COMMUNITY HEALTH WORKERS.

OCA supports Senate Bill 991. As Connecticut continues to confront a nationwide mental health crisis, including a dearth of services, workforce shortages, and rising need for treatment and support, all efforts must be considered to increase access to community-based supports. Reimbursement for Community Health Workers is a relatively low-cost investment to promote health equity, link underserved children and families to support services, and help engage families in linguistically and culturally competent ways.

I know that this Committee appreciates that the children's mental health crisis continues unabated. Here is recent information from the federal government about the state of children's mental health: Last week the U.S. Centers for Disease Control released a new report analyzing the most recent data and trends from its biannual Youth Risk Behavior Survey.[1] The YRBS surveys almost twenty thousand students across the country to generate the data regarding adolescent wellbeing.[2] The CDC conducts the national Youth Risk Behavior Survey (YRBS) every two years, most recently in 2021, among a nationally representative sample of U.S. public and private high school students. The survey asks youth

[1] https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf
[2] According to the CDC: "In each survey cycle, the national YRBS uses a three-stage cluster sample design to produce a nationally representative sample of students in grades 9–12 attending public (including charter schools), Catholic, and other non-public schools in the 50 states and the District of Columbia… Survey procedures are designed to protect students' privacy by allowing for anonymous and voluntary participation. Before survey administration, local parental permission procedures are followed… For the 2021 national YRBS, 17,508 questionnaires were completed in 152 schools. The data set was cleaned and edited for inconsistencies. Missing data were not statistically imputed. After editing, 17,232 questionnaires were usable. The school response rate was 73%, the student response rate was 79%, and the overall response rate, which is the product of the school and student response rates, was 58%." YRBS Report at 77-79.

questions regarding a range of behaviors including substance use, suicidal thoughts and behaviors, experiences with violence and poor mental health, social determinants of health such as unstable housing, and protective factors such as school connectedness and parental monitoring. The CDC's most recent report found that over the last 10 years, and evidenced in the recent data, most youth risk indicators have worsened. Excerpts from the CDC report issued this week include these alarming statistics:[3]

> **As we saw in the 10 years prior to the COVID-19 pandemic, mental health among students overall continues to worsen, with more than 40% of high school students feeling so sad or hopeless that they could not engage in their regular activities for at least two weeks during the previous year—a possible indication of the experience of depressive symptoms. We also saw significant increases in the percentage of youth who seriously considered suicide, made a suicide plan, and attempted suicide.**
>
> **Across almost all measures of substance use, experiences of violence, mental health, and suicidal thoughts and behaviors, female students are faring more poorly than male students. These differences, and the rates at which female students are reporting such negative experiences, are stark.**
>
> **In 2021, almost 60% of female students experienced persistent feelings of sadness or hopelessness during the past year and nearly 25% made a suicide plan.**
>
> **Close to 70% of LGBQ+ students experienced persistent feelings of sadness or hopelessness during the past year and more than 50% had poor mental health during the past 30 days. Almost 25% attempted suicide during the past year…**

The CDC recommends a system wide commitment to strengthening protective factors for children and families and increasing children's access to critical mental health assessments, supports and services. This bill is an important effort to ensure that the state is funding layers of workforce and family support.

H.B. No. 6587 (RAISED) AN ACT CONCERNING MEDICAID COVERAGE FOR DIAPERS.

OCA strongly supports this bill, which will ensure children's access to basic hygiene support and developmentally appropriate products. As written in the testimony submitted by the Diaper Bank of Connecticut, the provision of adequate diapers to children through Medicaid coverage will ensure that "children's health and development will improve as diseases associated with infrequent diaper changing, such as urinary tract infections and diaper dermatitis decrease; children will miss fewer days of preschool, and infants and toddlers will be better able to enroll in early education programs, increasing their school readiness and overall development." No family should have to decide between

[3] https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf

more groceries or more diapers, a reality that we know thousands of families likely face. We can and must do better for low-income infants and toddlers.

H.B. No. 6612 (RAISED) AN ACT CONCERNING NONPROFIT HEALTH AND HUMAN SERVICES PROVIDERS.

OCA supports the goals of this bill to provide adequate funding for non-profit service providers who deliver essential care to our state's most vulnerable individuals, including children. OCA has significant and persistent concerns regarding the lack of timely access to mental health services for children and families at all levels of care. A crisis of capacity continues to profoundly affect children throughout the state in several ways.

Medicaid Rates and COLA Rate Increases to Support Capacity at All Levels of Care.

Undergirding many of the state's capacity issues is the persistent under-funding of mental and behavioral health treatment by Medicaid and private insurance and the historical lack of adequate cost of living adjustments in state contracts for community-based services. Last year the Legislature passed Public Act 22-47, which Act required that the Office of Health Strategy, in consultation with DSS, analyze and report back to the Legislature regarding parity for behavioral health service reimbursement rates. OCA understands that the delivery of this report is delayed. Significant and urgent work however is needed to address the adequacy of reimbursement rates for children's mental and behavioral health services across the board, as without this investment workforce challenges cannot be solved, and capacity cannot be built and sustained. The state budget must respond to this paramount concern.

One recent example of the crisis in the children's mental health delivery system:

The state's capacity to deliver IICAPS services—a go to intensive home based service for children and families in crisis-- is strained to emergency levels, with Yale recently reporting to OCA that there are more than 500 families currently on the waiting list and multiple regions of the state have no providers at all (Windham and New London County). The state has lost providers and more are reportedly on the brink of closing. One agency recently reported to OCA that their wait list for this service was "infinite," with no resolution in sight. Families understandably cannot wait for a service meant to stabilize and support a child in crisis and waiting lists of weeks and months leave families bereft and desperate. While a recent rate increase was approved by DSS, more work remains to ensure adequate funding and access to services for families in crisis.

OCA Recommends Changes in State Law to Ensure Parity and Cost Based Analyses Inform Rate-Setting and Contracting with Non-Profit Providers

The state should implement additional Medicaid rate increases and state contract increases to ensure that reimbursement for care matches the real costs of delivering that care, including consideration of acuity factors affecting the child and family (e.g., risk of/use of hospitals and Emergency Departments, risk of out-of-home care). The state must implement a reliable and transparent methodology for rate setting and state agency contracting to help prevent the type of workforce shortages and access crisis we are trying to resolve now. The state must support flexible funding to allow providers to meet the treatment, advocacy, and social determinate needs of children and families.

Proposal: Amend Public Act 22-47 language to clarify the analysis regarding reimbursement rates for behavioral health services to ensure timely access to such services; and to establish a rate setting methodology. (language passed last session does not really do this).

Sec. 57. (Effective from passage) (a) The Office of Health Strategy shall study the rates at which health carriers delivering, issuing for delivery, renewing, amending or continuing individual and group health insurance policies in this state, and third-party administrators licensed under section 38a-720a of the general statutes, reimburse health care providers for covered physical, mental and behavioral health benefits. Such study shall include, but need not be limited to, an assessment of the: (1) Viability of implementing in this state a sliding scale of reimbursement rates; (2) extent to which reimbursement rates for covered mental and behavioral health benefits would need to increase in order to be consistent with the cost of delivering care and therefore adequate to [provide a financial incentive to] (A) attract additional health care providers to provide covered mental and behavioral health benefits to individuals in this state, and (B) encourage health care providers who provide covered mental and behavioral health benefits to accept new patients in this state; (3) potential aggregate savings that would accrue to health carriers in this state if insureds were to receive greater access to health care providers who provide covered mental and behavioral health benefits; (4) reimbursement rates for covered mental and behavioral health benefits provided by private health insurance policies in comparison to reimbursement rates for such benefits provided by the state or other governmental payors, providing that the Office of Health Strategies shall also analyze the extent to which the rates established by state and other governmental payors are aligned with the cost of delivering care, inclusive of contractual obligations for data collection and review required by state and other governmental payors; (5) reimbursement rates for covered mental and behavioral health benefits provided to children in comparison to reimbursement rates for such benefits provided to adults; and (6) number of children who are referred for covered mental and behavioral health benefits in comparison to the number of children who receive such benefits. (b) In conducting the study, the Office of Health Strategy may (1) coordinate with the Insurance Department, and (2) gather information needed to conduct the study from the all-payer claims database.

(c) (1) Not later than January 1, 2023, the Office of Health Strategy shall submit an interim report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to insurance and public health disclosing the results of the study conducted pursuant to subsections (a) and (b) of this section.

(2) Not later than January 1, 2024, the Office of Health Strategy shall submit a final report, in accordance with the provisions of section 11-4a of the general statutes, to said committees disclosing the results of such study[.]

(3) The state Medicaid authority shall adopt a methodology for setting rates that effectively addresses the cost of delivering care with consideration of patient and, where applicable, family acuity factors, including but not limited to, social determinates, risk of out-of-home placement, risk of hospitalization, and chronic school absenteeism.

OCA NOTE: OCA strongly supports requests from the Alliance for immediate increases in rates and state contracts for providers to urgently address current concerns regarding capacity, and behavioral health workforce recruitment and retention.

Respectfully submitted,

Sarah Healy Eagan, JD, Child Advocate, State of Connecticut